

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034476

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 54 Registrar's No. 2509

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED AUG 19 1963

VS 300
Rev. 4/59

1 4002
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Clayton		c. CITY OR TOWN Ferguson	
c. FULL NAME OF (If not in hospital, give location) St. Louis County Hospital		d. STREET ADDRESS (If outside, give location) 254 So. Harvey	
3. NAME OF DECEASED (Type or print) Catherine Landwehr		4. DATE OF DEATH Month August Day 5 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/4/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At. Home	
11a. FATHER'S NAME Henry Vanderbrink		11b. MOTHER'S MAIDEN NAME Mary Winter	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		13. INFORMANT Eugene Landwehr Ferguson Mo.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Post Amputation Left Leg		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Clayton, Mo.	
21. I attended the deceased from July 26, 1963 to August 5, 1963 and last saw her alive on Aug. 5, 1963 Death occurred at 6:15p m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Plw. Schaper M.D.	
22b. ADDRESS 601 S. Brentwood, Clayton, Mo.		22c. DATE SIGNED 8/6/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/8/63	23c. NAME OF CEMETERY OR CREMATORY St. Ferdinand Cemetery	23d. LOCATION (City, town, or county) (State) Florissant, Mo.
24. FUNERAL DIRECTOR White-Mullen Mort. Ferguson Mo.		25. DATE RECD. BY LOCAL REG. 8-7-63	
26. REGISTRAR'S SIGNATURE John B. Murphy M.D.			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Reinhold K. Rohmann

Licensed Embalmer No. 3395

P. O. Address St Louis 35 mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.